Jackson College Health Clinic

Influenza Vaccination Questionnaire

Patient Information:

Last Name:___________________________ First Name: _______________________________

Middle Initial: __________ Sex: Male / Female Date of Birth: ___________________

Phone Number: ________________________________

Address: ____

City: _________________________ State: _________________ Zip Code:________________

Check Correct Answer:

Are you sick at all today? Yes / No

Have you ever had an allergic reaction to any vaccine or vaccine component, including eggs in the past? Yes / No

Have you had any vaccine administered to you in the last 4 weeks? Yes / No

Vaccine Information Statement given Yes / No

I ACKNOWLEDGE THAT a copy of Jackson College Health Clinic Privacy Notice was made available to me. I know that I can ask for a copy of the Privacy Notice to take with me.

X________________________________

Please initial to acknowledge receipt

BY SIGNING MY NAME BELOW, I AGREE THAT I HAVE READ THIS FORM OR SOMEONE HAS READ THIS FORM FOR ME. I HAVE HAD THE CHANCE TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

X____ Date: ______________________

Patient or Patient Representative Signature

_ _

DO NOT WRITE BELOW THIS LINE- FOR CLINICAL STAFF ONLY

Lot# ____________________ Injection site: Left Deltoid Right Deltoid

Exp: ____________________ Left Thigh Right Thigh

Administration By: ____________________________________ Date: ____________________